Divine Dermatology, PLLC
2191 9th Ave. N. Suite 100
St. Petersburg, FL 33713
Phone: 727 528-0321 / Fax: 727 498-8832

Date: _____

Name: _____ Age: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Appointment Reminder Preference: Email / Text / Cell Phone / Home Phone / Work Phone

☐ ☐ ☐ ☐ ☐

Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

Marital Status: S M D W Spouse's Name: _____

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Primary Physician's Name: _____

Physician's Address: _____ Phone: _____

Emergency Contact: _____

Relationship to Patient: _____

Phone: _____ Legal Guardian (if applicable): _____

Insurance Company Name: _____

Address: _____ Phone: _____

Policy / ID / Member Number: _____ Group Number: _____

Name of Policy Holder: _____ Policy Holder's DOB: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please provide us with the following at the time of appointment:

- ▫ Government-issued photo ID
- ▫ Insurance cards (when applicable)

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Patient Name: _____ **DOB:** _____ **Date:** _____

Current Medical Status: Please check all that apply.

- ☐ Premedication prior to surgery
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Allergy to lidocaine
- ☐ Problems with healing
- ☐ Immunosuppression
- ☐ Hay fever
- ☐ Defibrillator
- ☐ Artificial joints within last 2 years
- ☐ Artificial heart valve
- ☐ Rapid heartbeat with epinephrine
- ☐ Chest pains
- ☐ Yeast infections with antibiotics
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Recent illness
- ☐ Pregnancy or planning a pregnancy
- ☐ Thyroid problems
- ☐ Blurry vision
- ☐ GI upset with antibiotics
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blood thinners (aspirin, Advil, Plavix)
- ☐ Problems with bleeding
- ☐ Problems with scarring (keloid)
- ☐ Problems with healing
- ☐ Changing mole
- ☐ History of Melanoma
- ☐ Rash
- ☐ Muscle weakness
- ☐ Joint aches
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Pacemaker

Primary reason for visit: _____

Second reason for visit: _____

Tertiary reason for visit: _____

Language Preference: _____

Ethnicity:

- ☐ White
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other

Ethnic Group:

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Other

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Past Medical History: Please check all that apply to your medical history

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atrial Fibrillation (irreg. heartbeat)
- ☐ Bone marrow transplant
- ☐ Breast cancer
- ☐ C.O.P.D. (chronic lung disease)
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage renal disease
- ☐ Enlarged Prostate
- ☐ G.E.R.D. (gastric reflux)
- ☐ Hearing loss
- ☐ Hepatitis (type): ____
- ☐ Anemia, Sickle Cell
- ☐ Hypertension
- ☐ HIV/Aids
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Valve Replacement (Heart)
- ☐ None
- ☐ Other: _____

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast (Mastectomy R)
- ☐ Breast (Mastectomy L)
- ☐ Breast (Mastectomy both)
- ☐ Breast (Lumpectomy R)
- ☐ Breast (Lumpectomy L)
- ☐ Breast (Lumpectomy both)
- ☐ Breast Biopsy
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colon (Colectomy) Cancer resection
- ☐ Colon (Colectomy) Diverticulitis
- ☐ Colon (Colectomy) IBS
- ☐ Gall Bladder (Cholecystectomy)
- ☐ Heart Coronary Artery Bypass Surgery
- ☐ Heart: PTCA (Cardiac Stent)
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement: Right Knee
- ☐ Joint Replacement: Left Knee
- ☐ Joint Replacement: Both Knees
- ☐ Joint Replacement: Right Hip
- ☐ Joint Replacement: Left Hip
- ☐ Joint Replacement: Both Hips
- ☐ Joint Replacement in past 2 years
- ☐ Kidney Biopsy
- ☐ Kidney Nephrectomy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries-Endometriosis
- ☐ Ovaries-Ovarian Cyst
- ☐ Ovaries-Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Prostate Biopsy
- ☐ Prostate: T.U.R.P.
- ☐ Skin Cancer: Basal Cell Carcinoma
- ☐ Skin Cancer: Squamous Cell Carcinoma
- ☐ Skin Cancer: Melanoma
- ☐ Skin Biopsy
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: Hysterectomy (Fibroids)
- ☐ Uterus: Hysterectomy (Cancer)

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SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratosis (precancerous lesions)
- ☐ Asthma/Eczema
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Fungal Infection
- ☐ Flaking or Itching Scalp
- ☐ Hair Loss
- ☐ Hay Fever/Allergies/Hives
- ☐ Herpes/Shingles
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles (Dysplastic nevus)
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Warts
- ☐ Other:_____

Do you wear sunscreen? Yes / No If yes, what SPF? _____

Do you use / have you used a tanning salon? Yes / No Frequency _____

FAMILY HISTORY

Do you have a family history of Melanoma/Skin Cancer? Yes / No If yes, which relative? _____

Other family history (ie: Psoriasis, Eczema, Diabetes, Asthma, Hay fever, Hair loss, Acne, Lupus)

See Attached Chart for Family History and for Immunizations Chart

_____

MEDICATIONS

Prescriptions: _____

Over the Counter/Supplements:_____

Allergies to medications: _____

Other Allergies: _____

SOCIAL HISTORY

- ☐ Sexually active with one partner
- ☐ Sexually active with more than one partner
- ☐ Alcohol use _____
- ☐ Drug use _____

SMOKING HISTORY

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker –when quit_____
- ☐ How long smoked/how much____
- ☐ Never smoked

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	Diabetes	Hay fever, Asthma, Eczema	High Blood Pressure	Hair loss	Stroke	Heart Attack/Heart Disease	Cancer or Melanoma	Psoriasis	Thyroid	Other
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Immunization History

Childhood Immunization	**Yes** ◯	**No** ◯
Booster Shots	**Yes** ◯	**No** ◯
Gardasil/HPV Vaccine	**Yes** ◯	**No** ◯
Phneumovax	**Yes** ◯	**No** ◯
Recent Flu Shot	**Yes** ◯	**No** ◯
Shingles Vaccine	**Yes** ◯	**No** ◯
Tetanus	**Yes** ◯	**No** ◯
Meningococcal Vaccine	**Yes** ◯	**No** ◯
Other / Travel Vaccine		

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Name: _____ **Date of Birth:** _____

We specialize in the following cosmetic procedures
Please indicate your desire for more information

- ☐ Blue Light Acne Treatment/PDT
- ☐ Botox / Dysport Cosmetic Injections
- ☐ Body Fat Treatments/Fotona Tightlaze Skin Tightening
- ☐ Chemical and Fruit Acid Peels
- ☐ Cleansing European & Acne Facials
- ☐ Dermal Fillers for Wrinkles/Scars (Juvéderm, Restylane, Perlane, Radiesse)
- ☐ Hair Loss Therapy
- ☐ Laser Hair Reduction
- ☐ Laser Facials & Treatments (Age Spots, Broken Capillaries, Wrinkles, Acne Scarring)
- ☐ Mesotherapy (Lipodissolve for small fatty areas)
- ☐ Microdermabrasion Skin Treatments
- ☐ Spider Vein Treatments
- ☐ Skin Rejuvenation (Micro needling)
- ☐ Fotona 4D Face Lift (Non-surgical skin tightening & lifting)

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Financial Responsibility

- Insurance companies set the amounts that they will pay for services.
- Insurance coverage is a contract between my insurance company and me.
- Most policies have identified deductibles, co-pays and/or yearly maximums.
- It is not the responsibility of this office to know what my deductible and/or co-pays are.
- Phone verification for benefits does not guarantee that I am covered.
- I am responsible for any balances due and will pay them promptly. I do understand that if I do not pay my balance within 60 days, my account will be sent to Collections where an additional 25-50% fee will be added to the balance.
- Payments for all co-pays are due at the time of service.
- My insurance company may or may not require referrals from my primary physician. It is my responsibility to initiate these if necessary.

Missed or Rescheduled Appointments

I understand that **I will be billed** $50.00 for a missed appointment/ for a cancellation or reschedule in less than 24-48 hours.

I HAVE READ THE ABOVE AND AGREE TO BE RESPONSIBLE FOR ALL PAYMENTS AND CO-PAYS TO THIS OFFICE

(Signature of Patient or Guarantor) (Date)

(Witness) (Date)

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Patient: _____ Date of Birth: _____

Divine Dermatology, PLLC has developed a comprehensive policy to preserve our patient's confidential medical information, also called "Protected Health Information". This Notice of Privacy Practices is available to you to read and review in the lobby of our office. A printed copy is also available to you upon request. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
• Protected Health Information may be disclosed or used for treatment, payment or healthcare operations.
• The Practice has a notice of Privacy Practices and that the Patient has the opportunity to review this notice.
• The Practice reserves the right to change the Notice of Privacy Practices.
• The Patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
• The Practice may revoke this consent in writing at any time and all future disclosures will then cease.
• The Practice may render treatment upon the execution of this Consent.

I hereby acknowledge that this information has been made readily available to me and I have had the opportunity to review the information contained herein.

_____ Date: _____
(Patient)

_____ _____
(Printed name of Patient/Guarantor) (Practice Representative)

In addition, I hereby give my permission for my Protected Health Information to be released, when necessary, to the following individuals, who are also my emergency contacts:
Name: _____ Relationship to Patient: _____

Phone: _____

Name: _____ Relationship to Patient: _____

Phone: _____

This information may include, but is not limited to, confirmation of appointments, test results, medication changes, progress reports etc. You may withdraw at any time informing Divine Dermatology's staff in writing.

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Divine Dermatology Office Policies

Thank You for choosing Divine Dermatology. By providing transparency of policy, we hope to ensure clarity in operations which promotes fairness.

(Initial)_____We accept cash, credit, debit and care credit for products and services. We accept Visa, MasterCard, American Express, and Discover.

(Initial)_____Your Co-Payment, co-insurance and/or deductible will be collected on the day of your visit. Any outstanding balance on your account will also, be collected before your visit.

(Initial)_____We have a 48 hr. appointment cancellation policy. We ask that you allow us the courtesy of at least 24 hours' notice to cancel or reschedule your appointment. We will bill $100.00 if you fail to comply with this policy twice in a 12 month period. **Please call 727.528.0321 to cancel or reschedule all appointments.**

(Initial)_____If you cancel your appointment and require refills and / or other services; you may be required to schedule an appointment to receive those services.

(Initial)_____If you have an emergency and need to see the doctor; please call our office and we will attempt to "work you in". If you have had surgery and want to speak to the doctor, you have been given the doctor's cell phone number with care instructions-Please; feel free to use it if the office is closed.

(Initial)_____Your Insurance and the terms of your policy are set and regulated by your insurance company. We will file a claim with your insurance company and any secondary policies on your behalf, however; Divine Dermatology will send you (2) statements if necessary and if we have not been paid in full within 90 days, Your account will be sent to a Collections Agency.

(Initial)_____We unfortunately, are not able to accept personal checks for cosmetic services or products.

(Initial)_____We do not dispense controlled substances over the telephone and rarely have a cause to dispense any at all.

(Initial)_____You may get a separate bill from a laboratory if you have a biopsy or other lab specific services. You should contact the number on the statement with questions or concerns about those bills.

(Initial)_____If you cancelled or rescheduled your appointment 3 times in a twelve month period or " No showed/Missed your appointment twice in a twelve month period-You will be released from this practice and no further appointments will be scheduled.

(Initial)_____If you have comments or concerns about your treatment or policy. Please feel free to write us at: 2191 9th Ave. North, Suite 100, St. Pete 33713, e-mail us: divinedermatology@yahoo.com or call.